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WEEKLY REPORT

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Fatal Pediatric Lead Poisoning — New Hampshire, 2000

Fatal pediatric lead poisoning is rare in the United States because of multiple public health measures that have reduced blood lead levels (BLLs) in the population. However, the risk for elevated BLLs among children remains high in some neighborhoods and populations, including children living in older housing with deteriorated leaded paint. This report describes the investigation of the first reported death of a child from lead poisoning since 1990 (*1*). The investigation implicated leaded paint and dust in a home environment as the most likely source of the poisoning. Lead poisoning can be prevented by correcting lead hazards, especially in older housing, and by screening children at risk according to established guidelines (*2*).

On March 29, 2000, a 2-year-old girl was seen at a community hospital emergency department with a low-grade fever and vomiting of approximately 1 day's duration. The child had been well since arriving in New Hampshire from Egypt with her Sudanese refugee family 3 weeks earlier. Laboratory findings included a microcytic anemia (hemoglobin: 7.6 g/dL; lower limit of normal: 11.5 g/dL) with occasional basophilic stippling of red blood cells. A throat swab streptococcal antigen screening test was positive. She was discharged from the emergency department with prescriptions for an antibiotic and antiemetic to treat presumed strep throat. However, her vomiting worsened, and she was admitted to the same hospital on April 17, and then transferred to a tertiary-care hospital the next day. On April 19, approximately 5 hours after the transfer, she became unresponsive, apneic, and hypotensive. She was intubated and placed on a ventilator. Computerized tomography of the head showed diffuse cerebral edema and dilated ventricles. Later that day, the results of a blood test drawn on April 18 showed a BLL of 391 µg/dL and an erythrocyte protoporphyrin level of 541 µg/dL. Chelation therapy was initiated with intramuscular British antilewisite and intravenous calcium ethylenediaminetetraacetic acid. Despite a decrease in her BLL to 72 µg/dL and treatment for increased intracranial pressure, including surgical ventricular drainage, she remained comatose without spontaneous respirations, brain electrical activity, and intracranial blood flow. She was pronounced brain dead on April 21.

An autopsy found diffuse cerebral edema. A hair sample lead concentration was 31 µg/g in the distal centimeter and 67 µg/g in the proximal centimeter, indicating a large increase in lead exposure during the preceding month. Radiographs of the left knee were equivocal for growth arrest lines that can occur in chronic lead poisoning (*3*). A bone marrow sample showed no stainable iron, indicating iron deficiency.

Fatal Pediatric Lead Poisoning — Continued

On April 19, the Manchester Health Department and New Hampshire Department of Health and Human Services (NHDHHS) initiated an investigation, including interviews and blood lead tests of the patient's family and an inspection of her residence. In addition, to assess a possible contribution of lead exposure from the child's previous residence in Egypt, the Field Epidemiology Training Program of the Egyptian Ministry of Health obtained soil and dust samples from that location.

After living in Egypt for approximately 18 months, on March 9, 2000, the family had moved to Manchester into an apartment constructed before 1920. A wall in a sibling's bedroom had multiple holes from which the patient had been seen removing and ingesting plaster. Two of seven samples of plaster with the adhering surface paint contained lead at levels of 5% and 12%. Peeling paint (35% lead) was present on the balusters and floor (3% lead) of a porch outside the apartment entrance where the patient sometimes had played. She also had played near and looked out of a living room window that occasionally was opened during meal preparation. A wipe sample of dust from the window well showed 6732 μg lead/ft^2, well above the hazardous level of 800 μg/ft^2 (*4*). NHDHHS ordered the apartment owner to correct the lead hazards identified during the inspection. The patient's family relocated to another dwelling.

BLLs in the mother and three siblings (ages 5, 11, and 15 years) ranged from 4–12 μg/dL. The family did not use or possess nontraditional remedies, food supplements, cosmetics, or ceramic eating or drinking containers acquired abroad. No one in the household was employed or had lead-related hobbies. Measurements of stable lead isotopes (*5*) in selected environmental samples and the patient's blood showed that the isotopic lead composition of the porch paint and window well dust in the her Manchester apartment matched the composition of lead in her blood more closely than did the isotopic composition of other samples, including those from her previous residence in Egypt.

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Editorial Note: Lead encephalopathy is a life-threatening complication of lead poisoning that can occur in young children who have very high BLLs (>70–100 μg/dL). Nonspecific symptoms (e.g., lethargy, sporadic vomiting, and constipation) can occur at BLLs >50–70 μg/dL and may precede the abrupt onset of frank encephalopathy characterized by persistent vomiting, ataxia, altered consciousness, coma, and seizures. In this report, the child's anemia with basophilic stippling also suggested lead poisoning. However, symptoms or signs cannot be used to reliably diagnose or exclude lead poisoning; a BLL must be measured whenever lead poisoning is suspected. In young children, BLLs >70 μg/dL or elevated BLLs with symptoms suggesting encephalopathy require prompt inpatient treatment with chelating agents to rapidly reduce BLLs. Providing appropriate intensive care for children with encephalopathy can prevent death, although severe permanent brain damage can occur despite treatment (*3*).

During the 1950s and 1960s, acute, often fatal, lead encephalopathy was a common cause of pediatric admissions to urban hospitals (*6*). The subsequent decline in fatal lead

Fatal Pediatric Lead Poisoning — Continued

poisoning cases is attributable to reduced lead exposure from multiple sources, institution of lead screening programs, and improved treatment of lead poisoning (*6*). Despite the reduction in severe lead poisoning, in some U.S. counties, >20% of young children tested have BLLs ≥10 μg/dL (*7*), high enough to adversely affect learning and development (*3*).

The likely sources of lead poisoning for the child in this report—deteriorated leaded paint and elevated levels of lead-contaminated house dust—are found in an estimated 24 million U.S. dwellings, 4.4 million of which are home to one or more children aged <6 years (U.S. Department of Housing and Urban Development, unpublished data, 2001). Lead hazards are especially common in homes built before 1960 (58%). Although the patient's pica and iron deficiency probably contributed to the severity of her lead poisoning, by increasing ingestion and absorption of lead (*3*), all children living in homes with lead hazards are at increased risk for developing elevated BLLs (*8*).

Children who are refugees, adoptees, or recent immigrants may be at increased risk for elevated BLLs, possibly related to lead exposure in their country of origin or to continued use of certain lead-containing traditional remedies or cosmetics. However, such children also are at risk for exposure to leaded paint hazards in older U.S. housing. In addition to ensuring that such children are screened after arrival in the United States, lead poisoning prevention programs and health-care providers should ensure that families receive timely education about lead hazards. Federal regulations require that property sellers and landlords provide families with information about lead poisoning and about any known lead hazards in a dwelling before its sale or lease.* Agencies providing health and social services to refugees and immigrants should become familiar with these regulations and ensure that appropriate information is provided to families in a language they can understand.

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*24 CFR Part 35, 40 CFR Part 745.

Evaluation of Sexually Transmitted Disease Control Practices for Male Patients With Urethritis at a Large Group Practice Affiliated With a Managed Care Organization — Massachusetts, 1995–1997

Effective management for sexually transmitted diseases (STDs) depends on appropriate testing, treatment, partner management, and complete and timely reporting of positive STD tests (*1*). Testing can ensure appropriate treatment of initial or recurrent infections and identification of drug-resistant pathogens, appropriate treatment can reduce risk for complications and development of drug resistance, and complete and timely reporting of positive test results by laboratories and STD cases by health-care providers to health departments can facilitate rapid sex partner notification and outbreak detection. By 1998, private providers, including those affiliated with commercial or Medicaid managed care organizations (MCOs) (*2,3*) were caring for approximately 70% of persons with chlamydia and 55% of persons with gonorrhea. To assess the quality of STD care at a MCO-affiliated multisite facility, the testing, treatment, and reporting practices of gonorrhea- and chlamydia-associated urethritis in male patients were evaluated. This report summarizes the evaluation, which indicated that the providers tested most men with urethritis symptoms, prescribed CDC-recommended therapy to all patients, and reported most laboratory-confirmed chlamydia and gonorrhea cases of urethritis to the state health department. Several interventions introduced at this large group practice may have encouraged these favorable STD practices.

Harvard Vanguard Medical Associates (HVMA), Massachusetts Department of Public Health (MDPH), and CDC evaluated a HVMA staff model component of Harvard Pilgrim Health Care during 1995–1997, when most staff in this multispecialty practice tested urethral specimens for chlamydia using enzyme immunoassays and for gonorrhea using culture. The MCO's formulary covered the CDC-recommended drugs for gonorrhea- and chlamydia-associated urethritis, including more expensive single-dose treatments (*4*). Each week day, HVMA-affiliated laboratories electronically transmitted positive test results to the patient's physician and the HVMA infection control (IC) practitioner responsible for case reporting; treatments were listed on the test result notice (*4*). By reviewing the electronic pharmacy file and the electronic and paper medical records, the IC practitioner determined whether treatment was prescribed or dispensed within 10 days after the test was ordered. A copy of the case report then was mailed to MDPH and the patient's physician. The physician's copy included CDC-recommended treatments to encourage appropriate future treatment decisions.

To evaluate testing and treatment practices during visits for symptomatic urethritis in men, 2247 medical records were identified in which diagnoses assigned during the visit included urethritis, nonspecific urethritis, urethral discharge, dysuria, or urethritis/chlamydia (*5*). Of the 2247 cases, 1988 (88%) were coded as urethritis and/or nonspecific urethritis. Testing and treatment information was abstracted from a random sample of 196 records. The interval between specimen collection and prescribing or dispensing a medication was determined by a review of medical records, HVMA's case database, and MDPH's surveillance database.

To evaluate completeness and timeliness of reporting to MDPH, a database was compiled of 393 cases of laboratory-confirmed gonorrhea and chlamydia infections diagnosed in men during 1995–1997. This database also included 31 symptomatic urethritis cases with positive chlamydia or gonorrhea tests that were included in the medical record review. The 393 case reports were matched with MDPH surveillance data by

Sexually Transmitted Disease Control Practices — Continued

name, date of birth, sex, specimen collection date, and disease type. Completeness of reporting was defined as the proportion of HVMA cases in the MDPH database. Timeliness of reporting was defined as the interval between specimen collection and entry of the laboratory report into MDPH's database.

Among the 196 cases of symptomatic urethritis sampled, 181 (92%) were tested for chlamydia infection, 163 (83%) for gonorrhea infection, or 161 (82%) for both infections. Sixteen (9%) specimens tested for chlamydia were positive. Fifteen (9%) tested for gonorrhea were positive. No specimen tested positive for both infections. All men with gonorrhea and 88% with chlamydia were prescribed CDC-recommended antibiotics when they initially presented with symptoms (before test results were available); the remaining men were prescribed treatment within 5 days of initial presentation. Among urethritis-associated cases, 11 (69%) of 16 positive for chlamydia and 14 (93%) of 15 positive for gonorrhea were matched with the MDPH database. Among the 393 cases positive for chlamydia or gonorrhea, 158 (78%) of 202 chlamydia cases and 156 (82%) of 191 gonorrhea cases in the HVMA database were matched with the MDPH database. Reports were entered into MDPH's database within a median of 16 days (range: 1–268 days) after specimen collection.

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Editorial Note: Most HVMA providers followed the CDC recommendation (*4*) to test men with symptomatic urethritis for chlamydial and gonococcal infection. The proportion of symptomatic urethritis associated with gonorrhea or chlamydia was consistent with another U.S. study (*6*); however, the HVMA testing practices were not consistent with earlier reports that MCO-affiliated providers may defer diagnostic testing because of cost constraints (*7*). HVMA-sponsored STD education for the provider and feedback from patients may have promoted testing at this practice. Introduction of more acceptable urine-based STD tests also may have increased testing rates.

The finding that most providers prescribed CDC-recommended treatments for urethritis (*8,9*) was not consistent with anecdotal reports that MCO-affiliated providers may defer expensive single-dose treatments that may improve patient adherence because of cost or formulary constraints (*7*). Interventions at this group practice that may have encouraged use of CDC-recommended treatments stemmed from collaboration with MDPH, which resulted in having these drugs available in the MCO formulary, listing CDC-recommended treatments on positive test reports and case report notices, and MDPH's disseminating CDC STD treatment guidelines to HVMA providers during the study period. Completeness of HVMA case reporting was higher in this study than in others (*10*). Providers may not report STD cases because of a lack of staff dedicated to reporting, time constraints, an inability to bill for reporting, concerns about confidentiality, and lack of awareness of reporting requirements (*1*). Interventions at HVMA that may have enhanced reporting completeness include 1) a central reporting system that did not require provider time; 2) electronic transfer of test results to the IC practitioner; 3) use of electronic records to verify prescribed and dispensed prescriptions; 4) HVMA's productive relation with MDPH; 5) Internet and newsletter communications to providers about rates of STDs in MCO members; and 6) a commitment to public health reporting.

Sexually Transmitted Disease Control Practices — Continued

The findings in this report are subject to at least four limitations. First, the selected diagnostic codes may not have identified all enrollees with urethritis-related symptoms, and testing and treatment information in medical records may have been incomplete. These factors may have resulted in an underestimate of the proportion of patients tested and prescribed appropriate treatment. Second, the case report matching procedure may have missed inexact matches (e.g., typographic errors). This may have resulted in a minor underestimate of completeness of reporting. Third, this evaluation was intended to provide information about STD control practices in this group practice and was not intended to compare the testing, treatment, and reporting practices before and after HVMA introduced interventions that may have improved performance. Finally, the evaluation did not compare STD control practices in this staff model group practice with other MCO-affiliated practices that lacked centralized laboratories, electronic pharmacy and medical records, and training and other education resources.

Some features of staff model practices, such as centralized local laboratories, may not be available in nonstaff model practices that now dominate the U.S. market. However, other features, such as dissemination of guidelines, may be easily implemented in other settings. Interventions to enhance STD control and surveillance can capitalize on the strengths of MCOs, specifically their coverage of large populations of persons at risk, affiliations with large numbers of health-care providers, and use of centralized data systems, procedures, guidelines, and policies. Comparative evaluations of MCO-affiliated practices that use different methods to promote appropriate testing, treatment, and reporting of STDs are needed to identify the most effective interventions in these settings.

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Racial Disparities in Median Age at Death of Persons With Down Syndrome — United States, 1968–1997

Down syndrome (DS) is the most common identified cause of mental retardation in the United States (*1*). The prevalence (approximately one in 800 live-born infants) is similar among all racial groups (*2*). Survival for the first year of life for infants with DS has improved dramatically during the last 50 years, from <50% in a 1942–1952 birth cohort (*3*) to 91% in a 1980–1996 cohort (*4*). Most studies of survival in persons with DS have focused on white populations, and little information is available about possible disparities among racial groups. To investigate changes in the age at death among persons with DS by race, CDC analyzed data from multiple-cause mortality files (MCMF) for 1968–1997. This report summarizes the results of the analysis, which indicate that the median age at death of persons with DS increased substantially during this period, but this increase was much greater for whites than for blacks or other races. Identification of the causes for this racial disparity may permit development of strategies to improve the survival of persons with DS, especially those who are black or of other racial groups.

MCMF compiled by CDC for 1968–1997 were used to study the median age at death among persons with DS by racial group (*5*). MCMF include demographic information about the decedent and codes for the underlying cause of death and co-morbid conditions listed on the death certificate. The underlying cause of death and contributing conditions are coded by the states and CDC using the *International Classification of Diseases, Adapted for Use in the United States* (ICDA-8) or the *Manual of the International Statistical Classification of Diseases, Injuries, and Cause of Death, based on the recommendations of the Ninth Revision Conference* (ICD-9). From 1968 through 1978, MCMF used ICDA-8 and included up to 14 conditions; from 1979 through 1997, MCMF used ICD-9 and included up to 20 conditions.

All deaths that contained the code for DS (ICDA-8 759.3 or ICD-9 758.0) anywhere in the record were selected. Records of persons aged 0 that included the code for pregnancy termination (ICDA-8 773 or ICD-9 779.6) were excluded. The remaining records were defined as "DS-associated deaths." Race was determined from a code in each MCMF record that classified the decedent as either white, black, or races other than white or black. Linear regression was used to test the trend of median age at death by year and estimate ß and its 95% confidence interval (CI).

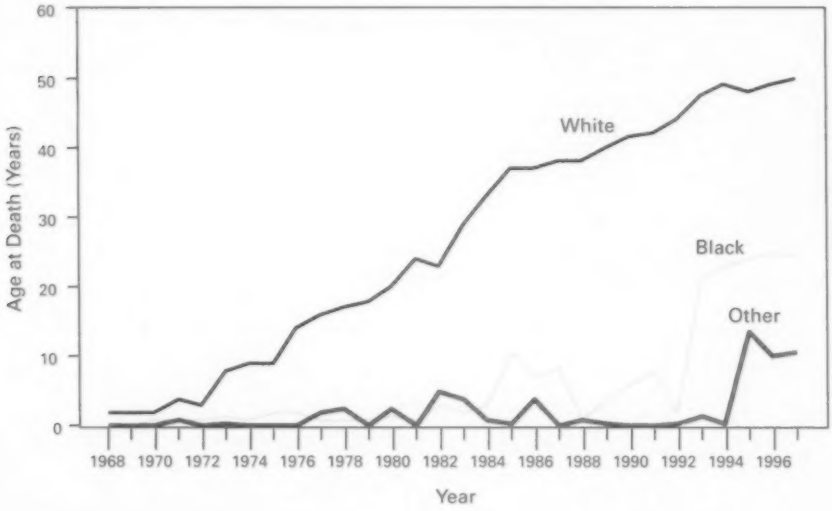
MCMF for 1968–1997 contained records for 33,900 DS-associated deaths. Of these, 64 deaths were excluded because they also were listed as pregnancy terminations. The remaining 33,836 cases represented 56 DS-associated deaths per 100,000 U.S. deaths. The racial distribution among persons with DS was 87.3% white, 11.0% black, and 1.7% other. Among all persons who died in the United States during this period, the racial distribution was 87.0% white, 11.9% black, and 1.1% other.

Among all 33,836 DS cases, the median age at death increased from 1 year in 1968 to 49 years in 1997, an average increase of 1.8 (95% CI=1.8–1.9) years per year studied. In comparison, the median age at death in the general population increased from 70 to 76 years or 0.2 (95% CI=0.2–0.3) year per year studied.

The median age at death for whites with DS increased from 2 years in 1968 to 50 years in 1997, an average increase of 1.9 (95% CI=1.8–2.0) years per year studied (Figure 1). For blacks during the same period, the median age at death increased from 0 in 1968 to 25 years in 1997, an average increase of 0.7 (95% CI=0.5–1.0) year per year studied. The median age at death for blacks with DS began to improve around 1982. For

Down Syndrome — Continued

FIGURE 1. Median age at death of persons with Down Syndrome, by race — United States, 1968–1997



persons with DS of other racial groups, the median age at death was 0 years in 1968 and 11 years in 1997, representing an average increase of 0.2 (95% CI=0.1–0.3) year per year studied. The median age at death among those with DS of other races began to improve around 1995. The median age at death increased more among persons with DS who were black after 1992 and among those who were of other races after 1995 than it did among whites.

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Editorial Note: The increase in the median age at death for persons with DS from 1 to 49 years since 1968 reflects substantially improved survival. However, racial disparity still exists in DS survival, and further study is needed to determine the causes of this disparity.

The findings in this report provide little information about the causes for either the improvement or the racial disparity in median age at death. During the study period, treatment of persons with DS changed markedly. In the 1960s, many were institutionalized and relatively few lived with their families after early childhood (*6*). Today, most children with DS live with their families, and older persons with DS often live in group homes or other facilities in the community (*6*). Medical care, especially treatment of congenital heart defects among persons with DS, also changed during the study period (*7*).

The findings in this report are subject to at least two limitations. First, the study is based on death certificates (*8*). The causes of death on death certificates may be incomplete or inaccurate, especially for medical conditions not usually resulting in death and for deaths occurring outside hospitals (*9*). In particular, DS may not be reported if the certifying physician did not feel that it caused or contributed to death. Incomplete reporting of DS is likely in this study because only approximately half the expected number of

Down Syndrome — Continued

DS-associated deaths was observed, assuming a DS prevalence of approximately one in 800 live-born infants (*2*). The proportion of death certificates that list DS as a diagnosis was similar among whites, blacks, and others, suggesting that the results were not influenced by differences in reporting the diagnosis among persons of different races. Second, this study did not account for the impact of differences and temporal changes in the distributions of age at death within racial groups in the general population. These factors may have contributed to the racial disparity and temporal changes observed.

Two factors that might account for the more limited improvement in median age at death of persons with DS who are black or of other races are differences in the frequency of life-threatening malformations and differences in social factors and care provided to persons with DS. No evidence exists that persons with DS who are black or members of other races are more likely to have life-threatening malformations. In this study, the proportion of persons with DS who also had congenital heart defects listed on their death certificates was similar among whites, blacks, and others.

Because differences in ascertainment or severity probably do not explain these observations, differences in care received by persons with DS might explain racial disparity in survival. Possibilities include differences in factors that may be associated with improved health in the general population such as socioeconomic status, education, community support, medical or surgical treatment of serious complications, or access to, use of, or quality of preventative health care. A combination of factors seems likely, as appears to be the case for racial disparity in mortality in the U.S. population in general (*10*). Additional study is needed to determine why persons with DS die much younger if they are black or of other races than if they are white. Identification of these factors may permit development of interventions to eliminate this racial disparity and further improve the survival of all persons with DS.

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Update: Influenza Activity — United States and Worldwide, 2000–01 Season, and Composition of the 2001–02 Influenza Vaccine

The 2000–01 influenza season was mild in the United States and was the first season since 1995–96 that was not predominated by A (H3N2) viruses. Influenza A (H1N1) viruses predominated in the United States. In some regions, however, influenza B viruses were reported more frequently than influenza A viruses. Worldwide, influenza A (H1N1) and B viruses also predominated. This report summarizes U.S.* and worldwide influenza activity during the 2000–01 influenza season and describes the composition of the 2001–02 influenza vaccine.

United States

Influenza activity increased in mid-December and peaked from mid-January through early February. Influenza A (H1N1) viruses predominated; however, the number of influenza type B viruses increased as the season progressed. Influenza B viruses were more frequently identified than influenza A viruses from the week ending February 10 through the week ending May 19 and were the predominant virus type identified in three of the nine surveillance regions.

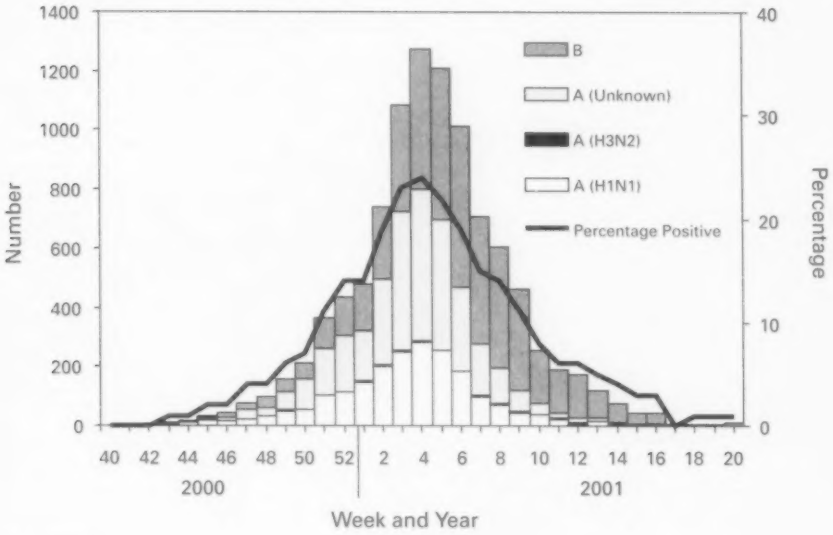
World Health Organization and National Respiratory and Enteric Virus Surveillance System collaborating laboratories in the United States tested 88,598 respiratory specimens for influenza during October 1, 2000–May 19, 2001; 9962 (11%) were positive (Figure 1). Of these, 5337 (54%) were positive for influenza type A and 4625 (46%) were positive for influenza type B. Of the 2127 subtyped influenza A viruses, 2061 (97%) were type A (H1N1) and 66 (3%) were A (H3N2). Influenza type B viruses were isolated more frequently than type A viruses from the week ending February 10 through the week ending May 19. Influenza type A viruses predominated in the East North Central, South Atlantic, West North Central, and West South Central regions; influenza B viruses predominated in the mid-Atlantic, Mountain, and Pacific regions. The East South Central and New England regions reported approximately equal numbers of influenza A and B viruses. The proportion of specimens testing positive for influenza first increased to ≥10% during the week ending December 23, 2000, peaked at 24% during the week ending January 27, 2001, and declined to <10% during the week ending March 10. The peak percentage of specimens testing positive for influenza during the 2000–01 season was lower than that seen during the previous three seasons when the peak ranged from 28% to 32%.

CDC antigenically characterized 678 influenza viruses received from U.S. laboratories since October 1; 335 (95%) of the 354 influenza A (H1N1) viruses were similar to A/New Caledonia/20/99, the H1N1 component of the 2000–01 influenza vaccine, and 19 (5%) were similar to A/Bayern/07/95. Although A/Bayern-like viruses are distinct from the A/New Caledonia-like viruses, the A/New Caledonia/20/99 vaccine strain produces high titers of antibody that cross-react with A/Bayern/07/95-like viruses. Of the 23 influenza A (H3N2) viruses that were characterized, all were similar to the vaccine strain A/Panama/2007/99. Of the 301 influenza B viruses that were characterized, 33 (11%) were similar to the vaccine strain, B/Beijing/184/93, and 268 (89%) were most closely related to the B/Sichuan/379/99 reference strain.

*The four components of the influenza surveillance system have been described (*1*). Information reported as of June 5, 2001.

Influenza Activity — Continued

FIGURE 1. Number* and percentage of respiratory specimens testing positive for influenza reported by World Health Organization and National Respiratory and Enteric Virus Surveillance System collaborating laboratories, by week and year — United States, 2000–01 season



* n=9962.

U.S. influenza sentinel physicians reported that the percentage of patient visits for influenza-like illness (ILI)[†] exceeded baseline levels (0–3%) for 4 consecutive weeks from the week ending January 20 through the week ending February 10. During each of the 4 weeks, 4% of patient visits were for ILI. During the previous three influenza seasons, the peak percentage of patient visits for ILI ranged from 5% to 7%.

On the basis of data from state and territorial epidemiologists' reports, influenza activity peaked during the weeks ending February 3 and February 10, when 38 states reported regional or widespread influenza activity[§]. State and territorial epidemiologists reported regional influenza activity during consecutive weeks from the week ending November 18 through the week ending March 31. Widespread activity was reported by one or more states during consecutive weeks for the week ending January 6 through the week ending March 10. The peak number of states reporting regional or widespread activity during the previous 3 years ranged from 43 to 46.

[†] Temperature ≥100.0 F (≥37.8 C) and either cough or sore throat in the absence of a known cause.

[§] Levels of activity are 1) *no activity*; 2) *sporadic*—sporadically occurring ILI or culture-confirmed influenza with no outbreaks detected; 3) *regional*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of <50% of the state's population; and 4)*widespread*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of ≥50% of the state's population.

Influenza Activity — Continued

As reported through the 122 Cities Mortality Reporting System, the percentage of deaths in the United States associated with pneumonia and influenza (P&I) did not exceed the epidemic threshold[¶] during the 2000–01 influenza season. During the previous three seasons, the percentage of deaths attributed to P&I was above the epidemic threshold for 10 consecutive weeks each season.

Worldwide

During October 2000–April 2001, influenza A (H1N1) and influenza B viruses circulated widely in Africa, the Americas, Asia, and Europe and influenza A (H3N2) viruses were reported sporadically. Influenza A (H1N1) viruses predominated in most European countries (Albania, Austria, Belgium, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Italy, Latvia, the Netherlands, Norway, Romania, Russia, Slovakia, Spain, Switzerland, Ukraine, and Yugoslavia). Influenza A (H1N1) viruses also were reported from Asia (China, Hong Kong/China, Iran, Israel, Japan, Republic of Korea, Nepal, Singapore, and Thailand), Africa (Mauritius and Morocco), the Americas (Canada, Jamaica, Mexico, Panama, and Peru), other European countries (Iceland, Ireland, Portugal, Sweden, and the United Kingdom), and Oceania (Australia).

Influenza type B viruses were identified more frequently than influenza A viruses in Canada, China, Egypt, Iceland, Ireland, Hong Kong/China, Portugal, Sweden, and the United Kingdom. Influenza type B viruses also were reported in Argentina, Australia, Brazil, Chile, India, Israel, Japan, Republic of Korea, Mauritius, Paraguay, Peru, Singapore, Taiwan, Thailand, and throughout Europe.

Influenza A (H3N2) viruses were identified in Argentina, Australia, Brazil, Bulgaria, Canada, Chile, China, Czech Republic, Denmark, France, Germany, Hong Kong/China, Ireland, Italy, Japan, Republic of Korea, Peru, Portugal, Russia, Singapore, South Africa, Spain, Switzerland, Taiwan, and Thailand. Unsubtyped influenza A viruses were reported from Belarus, Chile, Colombia, Malaysia, Nepal, Paraguay, and Slovenia.

Composition of the 2001–02 Influenza Vaccine

The Food and Drug Administration's Vaccines and Related Biological Products Advisory Committee (VRBPAC) recommended that the 2001–02 trivalent influenza vaccine for the United States contain A/New Caledonia/20/99-like (H1N1), A/Moscow/10/99-like (H3N2), and B/Sichuan/379/99-like viruses. This recommendation was based on antigenic analyses of recently isolated influenza viruses, epidemiologic data, and postvaccination serologic studies in humans.

Most influenza A (H1N1) viruses isolated worldwide were similar to A/New Caledonia/20/99 (H1N1). Both A/New Caledonia/20/99 and A/Bayern/07/95-like (H1N1) viruses circulated in the United States. Although these viruses antigenically are distinct, antibodies produced against A/New Caledonia/20/99 react at equivalent levels with A/Bayern/07/95-like viruses (*2*); therefore, A/New Caledonia/20/99 was retained in the 2001–02 influenza vaccine.

[¶] Before the 1999–2000 season, the case definition for P&I deaths was modified. CDC analysis estimated that the revised case definition resulted in an average increase in baseline P&I mortality estimates of 0.8% for 1999–2000. Thus, the 122 cities P&I mortality baseline and epidemic threshold for the 2000–01 season have been adjusted upward. The epidemic threshold is 1.645 standard deviations above the seasonal baseline. The expected seasonal baseline is projected using a robust regression procedure in which a periodic regression model is applied to observed percentages of deaths from P&I since 1983.

Influenza Activity — Continued

Most influenza A (H3N2) viruses isolated during the 2000–01 season were similar to A/Panama/2007/99 and A/Moscow/10/99-like (H3N2) viruses. Antibodies produced following vaccination with the 2000–01 vaccine containing the A/Panama/2007/99 (H3N2) virus reacted equally well with recent influenza A (H3N2) viruses and the vaccine strain (*2*); therefore, VRBPAC recommended that an influenza A/Moscow/10/99-like (H3N2) virus be retained in the 2001–02 vaccine. Because of its growth properties, U.S. vaccine manufacturers will use the antigenically equivalent virus, A/Panama/2007/99.

Most influenza B isolates were related more closely to the antigenic drift variant B/Sichuan/379/99 than the 2000–01 B/Beijing/184/93-like vaccine strain, B/Yamanashi/166/98. Antibodies produced against the B/Yamanashi/166/98 vaccine strain cross-reacted with B/Sichuan/379/99-like viruses; however, antibodies were lower in titer and frequency against B/Sichuan/379/99-like viruses than B/Yamanashi/166/98-like viruses (*2*). Therefore, VRBPAC recommended that the influenza B component be updated for the 2001–02 vaccine to an influenza B/Sichuan/379/99-like virus. For the B/Sichuan/379/99-like virus, U.S. manufacturers will use one of the antigenically equivalent viruses B/Johannesburg/05/99, B/Victoria/504/2000, or B/Guangdong/120/2000.

Reported by: World Health Organization National Influenza Centers, Communicable Diseases, Surveillance and Response, World Health Organization, Geneva, Switzerland. A Hay, PhD, WHO Collaborating Center for Reference and Research on Influenza, National Institute for Medical Research, London, England. I Gust, MD, A Hampson, WHO Collaborating Center for Reference and Research on Influenza, Parkville, Australia. M Tashiro, MD, WHO Collaborating Center for Reference and Research on Influenza, National Institute of Infectious Diseases, Tokyo, Japan. Participating state and territorial epidemiologists and state public health laboratory directors. WHO collaborating laboratories. National Respiratory and Enteric Virus Surveillance System laboratories. Sentinel Physicians Influenza Surveillance System. Surveillance Systems Br, Div of Public Health Surveillance and Informatics, Epidemiology Program Office; WHO Collaborating Center for Reference and Research on Influenza, Influenza Br and Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: Influenza A (H1N1) and B viruses co-circulated in the United States and worldwide during the 2000–01 influenza season. Influenza A (H3N2) viruses were isolated sporadically and no country reported widespread activity as a result of influenza A (H3N2) viruses. Seasons in which influenza A (H1N1) and/or influenza B viruses predominate typically have been less severe than seasons in which influenza A (H3N2) viruses circulate widely (*3*). The level of influenza activity reported this season was consistent with a number of other A (H1N1) and B predominant years.

Although influenza epidemics typically peak during December–March in the temperate regions of the Northern Hemisphere, sporadic cases and outbreaks can occur during the summer (*4–6*). The influenza season typically peaks during May–August in temperate regions of the Southern Hemisphere, and epidemics can occur at any time of the year in the tropics. U.S. physicians should consider influenza when diagnosing a febrile respiratory illness during the summer, particularly among persons who have traveled recently in the tropics, Southern Hemisphere, or with large international groups. Persons at increased risk for influenza-related complications who were not vaccinated during the preceding fall or winter should consider receiving influenza vaccine, if available, before traveling to the tropics, Southern Hemisphere, or with large international groups. Persons at increased risk for influenza-related complications who have received the previous season's vaccine during the summer should be vaccinated with the current influenza vaccine during the following fall or winter.

Influenza Activity — Continued

References

1. CDC. Influenza activity—United States, 1999–2000 season. MMWR 1999;48:1039–42.
2. World Health Organization. Recommended composition of influenza virus vaccines for use in the 2001–2002 season. Wkly Epidemiol Rec 2001;76:58–61.
3. Simonsen L, Fukuda K, Schoneberger LB, Cox NJ. The impact of influenza epidemics on hospitalizations. J Infect Dis 2000;181:831–7.
4. CDC. Influenza A—Florida and Tennessee, July–August 1998, and virologic surveillance of influenza, May–August 1998. MMWR 1998;47:756–9.
5. CDC. Update: outbreak of influenza A infection—Alaska and the Yukon territory, July–August 1998. MMWR 1998;47:685–8.
6. CDC. Outbreak of influenza A infection among travelers—Alaska and the Yukon Territory, May–June 1999. MMWR 1999;48:545–6,555.

Notice to Readers

Shortage of Spectinomycin

In April 2001, Pharmacia Corporation (Peapack, New Jersey) announced it was discontinuing U.S. production of spectinomycin (Trobicin®)* because of low sales volume; remaining spectinomycin inventory will expire on June 30, 2001. No other pharmaceutical company manufactures or sells spectinomycin in the United States.

CDC recommends treating patients infected with *Neisseria gonorrhoeae* who have contraindications to cephalosporins and fluoroquinolones with spectinomycin (*1*). Patients in this category include: 1) pregnant women with documented cephalosporin allergies (fluoroquinolones are contraindicated in pregnancy); and 2) patients with documented cephalosporin allergies who acquired gonorrhea infection in areas where fluoroquinolone-resistant *N. gonorrhoeae* is endemic (e.g., Asia, Hawaii, and other Pacific Islands) (*2*).

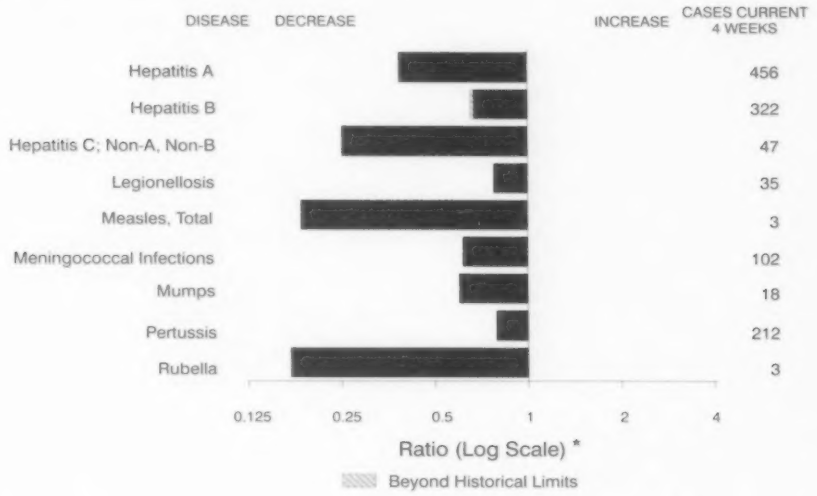
For access to spectinomycin until June 30, contact Wendy Johnson, Pharmacia Corporation, telephone (800) 976-7741, ext. 30110 or fax (800) 852-6421. In response to this shortage, CDC and the Food and Drug Administration are working with Pharmacia Corporation to identify a solution. Interim alternative treatment recommendations are available at http://www.cdc.gov/std/specshortage.htm or from CDC's Fax Information System (888) 232-3299 ([888] CDC-FAXX), by entering document number 210100.

References

1. CDC. 1998 Guidelines for treatment of sexually transmitted diseases. MMWR 1998;47(no. RR-1).
2. CDC. Fluoroquinolone-resistance in *Neisseria gonorrhoeae*, Hawaii, 1999, and decreased susceptibility to azithromycin in *N. gonorrhoeae*, Missouri, 1999. MMWR 2000;49:833–7.

* Use of trade names is for identification only and does not imply endorsement by CDC or the U.S. Department of Health and Human Services.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending June 2, 2001, with historical data



* Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending June 2, 2001 (22nd Week)

	Cum. 2001		Cum. 2001
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis*	24	Psittacosis*	4
Cholera	3	Q fever*	7
Cyclosporiasis*	69	Rabies, human	-
Diphtheria	1	Rocky Mountain spotted fever (RMSF)	73
Ehrlichiosis: human granulocytic (HGE)*	31	Rubella, congenital syndrome	-
human monocytic (HME)*	8	Streptococcal disease, invasive, group A	1,662
Encephalitis: California serogroup viral*	-	Streptococcal toxic-shock syndrome*	24
eastern equine*	-	Syphilis, congenital†	55
St. Louis*	-	Tetanus	6
western equine*	-	Toxic-shock syndrome	58
Hansen disease (leprosy)*	25	Trichinosis	5
Hantavirus pulmonary syndrome*†	3	Tularemia*	15
Hemolytic uremic syndrome, postdiarrheal*	29	Typhoid fever	95
HIV infection, pediatric*†	84	Yellow fever	-
Plague	-		

-: No reported cases.
*Not notifiable in all states.
† Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update May 29, 2001.
§ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending June 2, 2001, and June 3, 2000 (22nd Week)

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	15,380	16,292	263,099	285,785	606	621	524	723	376	624
NEW ENGLAND	586	987	9,439	9,687	23	36	59	86	46	84
Maine	18	16	540	563	3	6	7	6	7	6
N.H.	14	13	528	435	-	2	10	5	7	7
Vt.	10	1	242	223	10	11	2	3	1	4
Mass.	332	669	4,250	4,150	5	10	24	41	21	35
R.I.	44	40	1,140	1,095	3	2	4	3	2	5
Conn.	168	248	2,739	3,221	2	5	12	28	8	27
MID. ATLANTIC	3,108	3,928	26,142	27,104	64	121	43	105	36	80
Upstate N.Y.	182	181	4,860	518	34	30	35	75	25	38
N.Y. City	1,587	2,313	10,071	11,477	25	76	1	7	1	3
N.J.	746	832	3,130	5,158	2	4	7	23	10	19
Pa.	593	602	8,081	9,951	3	11	N	N	-	20
E.N. CENTRAL	1,163	1,590	37,127	49,344	192	131	115	132	68	91
Ohio	198	196	4,395	12,737	46	21	37	23	25	17
Ind.	119	146	6,057	5,396	25	9	20	15	10	16
Ill.	558	1,002	10,470	14,415	1	18	18	40	19	30
Mich.	224	184	12,258	9,791	47	19	21	23	-	19
Wis.	64	62	3,947	7,005	73	64	19	31	14	9
W.N. CENTRAL	355	358	13,655	16,128	32	43	70	100	63	99
Minn.	67	78	2,582	3,354	-	10	30	26	33	38
Iowa	40	36	1,490	2,170	18	12	10	15	7	9
Mo.	168	149	4,941	5,392	6	6	10	28	12	24
N. Dak.	1	-	388	374	2	3	1	6	3	6
S. Dak.	9	3	780	745	3	5	6	2	4	5
Nebr.	27	25	947	1,535	3	4	5	16	-	13
Kans.	43	67	2,527	2,558	-	3	8	7	4	4
S. ATLANTIC	4,910	4,276	52,637	52,147	129	99	54	60	23	50
Del.	84	77	1,234	1,259	1	2	-	1	-	-
Md.	591	455	5,153	5,241	25	6	3	8	-	1
D.C.	360	315	1,515	1,367	9	2	-	-	U	U
Va.	388	295	6,738	6,650	7	4	13	14	8	15
W. Va.	35	27	972	884	-	3	1	3	-	3
N.C.	212	255	7,698	8,676	14	9	21	9	9	7
S.C.	340	293	5,239	3,931			2	4	2	3
Ga.	579	429	10,379	10,642	44	53	6	7	2	11
Fla.	2,321	2,130	13,709	13,497	29	20	8	14	2	10
E.S. CENTRAL	836	767	19,488	20,863	14	20	22	35	14	25
Ky.	181	98	3,532	3,370	1	1	5	11	5	10
Tenn.	249	314	6,424	5,981	2	3	11	14	8	12
Ala.	182	206	4,708	6,508	5	9	6	2	-	1
Miss.	224	149	4,824	5,004	6	7	-	8	1	2
W.S. CENTRAL	1,617	1,475	42,459	43,518	10	30	29	39	37	75
Ark.	89	92	3,230	2,609	2	1	2	4	-	19
La.	403	265	6,999	7,878	4	6	1	4	14	14
Okla.	90	112	4,282	3,878	2	2	9	7	8	5
Tex.	1,035	1,006	27,948	29,153	2	21	17	24	15	37
MOUNTAIN	636	552	14,219	16,841	46	31	57	58	39	36
Mont.	12	7	921	601	5	4	5	9	-	-
Idaho	14	11	730	784	5	3	6	9	-	4
Wyo.	1	2	338	310	-	3	1	4	-	3
Colo.	126	130	1,149	5,107	15	8	26	17	20	9
N. Mex.	50	58	2,538	2,102	8	1	4	3	2	3
Ariz.	258	170	5,960	5,262	1	2	7	14	9	13
Utah	53	57	447	1,079	10	8	5	1	7	2
Nev.	122	117	2,136	1,596	2	2	3	1	1	2
PACIFIC	2,169	2,359	47,933	50,153	96	110	75	108	50	84
Wash.	247	243	5,834	5,429	N	U	17	26	13	43
Oreg.	104	86	1,222	2,939	3	3	15	16	8	19
Calif.	1,787	1,962	39,544	39,257	91	107	41	57	27	14
Alaska	9	5	1,085	1,045	-	-	1	1	-	1
Hawaii	22	63	248	1,483	2	-	1	8	2	7
Guam	9	13	-	224	-	-	N	N	U	U
P.R.	535	431	2,090	U	-	-	-	3	U	U
V.I.	2	18	53	-	-	-	-	-	U	U
Amer. Samoa	-	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	53	U	-	U	-	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

† Chlamydia refers to genital infections caused by *C. trachomatis*. Totals reported to the Division of STD Prevention, NCHSTP.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update May 29, 2001.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending June 2, 2001, and June 3, 2000 (22nd Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	120,174	140,367	924	1,445	266	283	154	1,006	2,509
NEW ENGLAND	2,586	2,678	12	12	16	19	17	337	498
Maine	57	34	-	-	-	2	-	-	-
N.H.	59	40	-	-	4	2	-	46	31
Vt.	36	26	5	3	4	1	-	1	7
Mass.	1,316	1,060	7	6	5	9	11	72	188
R.I.	283	269	-	3	1	2	1	35	-
Conn.	835	1,249	-	-	2	3	5	183	272
MID. ATLANTIC	12,328	14,979	32	297	30	77	24	381	1,579
Upstate N.Y.	3,121	2,539	20	12	19	20	10	294	435
N.Y. City	4,255	4,800	-	-	4	10	5	1	55
N.J.	1,118	2,892	-	264	4	8	6	7	539
Pa.	3,834	4,748	12	21	3	39	3	79	550
E.N. CENTRAL	20,124	28,170	97	111	73	73	20	26	111
Ohio	2,927	7,157	5	3	41	33	4	22	13
Ind.	2,495	2,451	1	-	6	9	3	1	2
Ill.	6,376	8,687	10	12	-	7	-	-	9
Mich.	7,109	6,936	81	96	18	14	12	-	7
Wis.	1,217	2,939	-	-	8	10	1	3	80
W.N. CENTRAL	5,687	6,861	310	236	20	15	4	36	38
Minn.	823	1,333	1	4	1	1	-	23	14
Iowa	392	446	-	1	5	3	-	4	-
Mo.	3,001	3,317	305	225	9	8	1	7	14
N. Dak.	14	26	-	-	-	-	-	-	-
S. Dak.	113	110	-	-	-	1	-	-	-
Nebr.	275	567	1	2	4	-	1	-	1
Kans.	1,069	1,062	3	4	1	2	2	2	9
S. ATLANTIC	31,942	36,075	47	34	44	45	26	168	219
Del.	681	703	-	2	-	4	-	2	37
Md.	2,948	3,589	12	2	8	10	2	118	134
D.C.	1,282	960	-	1	2	-	-	7	1
Va.	3,311	4,071	-	1	6	3	5	30	25
W. Va.	237	282	5	5	N	N	3	1	8
N.C.	6,306	7,141	8	12	4	6	-	5	8
S.C.	3,798	3,504	3	-	1	2	2	1	2
Ga.	5,649	6,496	-	1	2	4	7	-	-
Fla.	7,730	9,329	19	10	21	16	7	4	4
E.S. CENTRAL	12,477	14,741	91	196	24	8	8	6	10
Ky.	1,376	1,407	3	16	6	5	2	2	2
Tenn.	4,201	4,584	28	43	10	1	3	2	6
Ala.	3,831	4,982	2	6	6	1	3	2	1
Miss.	3,069	3,768	56	131	2	1	-	-	1
W.S. CENTRAL	20,321	22,407	154	458	4	12	4	7	20
Ark.	1,990	1,381	3	3	-	-	1	-	-
La.	4,758	5,578	67	235	2	6	-	1	1
Okla.	1,948	1,716	3	2	2	1	-	-	-
Tex.	11,625	13,732	81	218	-	5	3	6	19
MOUNTAIN	4,306	4,319	128	29	20	16	16	4	1
Mont.	46	20	-	1	-	-	-	-	-
Idaho	33	37	1	1	-	3	1	2	-
Wyo.	23	27	101	1	1	-	1	1	1
Colo.	1,300	1,353	10	5	6	6	2	-	-
N. Mex.	410	451	9	6	1	1	3	-	-
Ariz.	1,676	1,743	4	11	6	2	3	-	-
Utah	41	112	-	-	4	4	1	-	-
Nev.	777	576	3	4	2	-	5	1	-
PACIFIC	10,403	10,137	53	72	35	18	35	41	33
Wash.	1,235	954	13	9	6	8	2	2	-
Oreg.	188	383	7	15	N	N	1	3	3
Calif.	8,792	8,475	33	48	29	10	32	36	29
Alaska	133	133	-	-	-	-	-	-	1
Hawaii	55	192	-	-	-	-	-	N	N
Guam	-	22	-	1	-	-	-	-	-
P.R.	653	241	-	1	2	-	-	N	N
V.I.	6	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	3	U	-	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending June 2, 2001, and June 3, 2000 (22nd Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	355	475	2,448	2,686	10,073	11,730	8,456	11,419
NEW ENGLAND	26	19	246	298	777	694	776	727
Maine	3	3	31	61	95	51	74	35
N.H.	2	1	7	4	58	48	57	47
Vt.	-	2	34	26	33	48	34	55
Mass.	6	8	78	95	440	402	393	399
R.I.	3	3	26	20	42	25	59	52
Conn.	12	2	70	92	109	120	159	139
MID. ATLANTIC	66	95	341	462	1,007	1,773	1,437	1,935
Upstate N.Y.	18	20	267	280	366	375	360	514
N.Y. City	34	48	5	3	340	478	438	501
N.J.	8	13	67	67	204	463	218	364
Pa.	6	14	2	112	97	457	421	556
E.N. CENTRAL	42	58	17	25	1,402	1,700	1,141	1,667
Ohio	9	5	3	4	492	397	412	399
Ind.	9	3	1	-	143	187	119	204
Ill.	1	33	3	1	316	544	255	586
Mich.	16	11	10	13	252	333	226	361
Wis.	7	6	-	7	199	239	129	117
W.N. CENTRAL	14	22	144	232	651	685	659	848
Minn.	6	7	16	33	211	104	240	240
Iowa	1	1	29	33	104	92	95	98
Mo.	3	3	13	12	158	241	211	296
N. Dak.	-	2	18	57	10	15	20	29
S. Dak.	-	-	21	48	42	32	32	39
Nebr.	2	3	1	-	47	72	-	53
Kans.	2	6	46	49	79	129	61	93
S. ATLANTIC	93	111	889	923	2,457	1,970	1,529	1,721
Del.	1	2	16	18	29	36	27	40
Md.	36	38	100	169	251	270	262	310
D.C.	4	5	-	-	29	23	U	U
Va.	21	25	178	235	409	265	328	282
W. Va.	1	-	57	54	36	50	33	46
N.C.	2	10	256	232	402	281	194	258
S.C.	4	1	50	51	269	159	260	143
Ga.	3	4	135	109	345	333	352	481
Fla.	21	26	97	55	687	553	73	161
E.S. CENTRAL	10	16	83	79	549	558	325	468
Ky.	2	3	10	10	103	128	72	87
Tenn.	5	5	60	45	152	132	115	211
Ala.	3	7	13	24	198	157	109	140
Miss.	-	1	-	-	96	141	29	30
W.S. CENTRAL	5	24	480	446	988	1,308	880	799
Ark.	2	1	-	-	144	122	92	94
La.	1	4	-	-	218	228	214	173
Okla.	1	1	38	30	80	108	63	94
Tex.	1	18	442	416	546	850	511	438
MOUNTAIN	19	19	95	98	703	959	565	905
Mont.	2	1	16	24	29	42	-	-
Idaho	2	-	1	1	40	52	4	48
Wyo.	-	-	16	28	27	24	16	20
Colo.	9	10	-	-	192	299	200	293
N. Mex.	1	-	3	7	91	84	66	78
Ariz.	1	2	59	37	191	218	182	232
Utah	2	3	-	1	79	143	74	140
Nev.	2	3	-	-	54	97	23	94
PACIFIC	80	111	153	123	1,539	2,083	1,144	2,349
Wash.	2	8	-	-	163	174	205	258
Oreg.	4	22	-	-	67	130	109	170
Calif.	70	78	120	100	1,246	1,685	704	1,832
Alaska	1	-	33	23	16	23	2	19
Hawaii	3	3	-	-	47	71	124	70
Guam	-	-	-	-	-	11	U	U
P.R.	-	4	61	25	104	176	U	U
V.I.	-	-	-	-	-	-	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	5	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending June 2, 2001, and June 3, 2000 (22nd Week)

Reporting Area	Shigellosis*				Syphilis (Primary & Secondary)		Tuberculosis	
	NETSS		PHLIS					
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	4,881	7,493	2,599	4,333	2,105	2,637	4,303	5,388
NEW ENGLAND	74	131	82	106	18	36	152	155
Maine	3	5	1	-	-	1	5	3
N.H.	1	1	1	4	1	1	7	4
Vt.	3	1	2	-	1	-	2	2
Mass.	49	92	52	69	11	26	92	95
R.I.	7	10	9	10	1	1	13	15
Conn.	11	22	17	23	4	7	33	36
MID. ATLANTIC	391	1,147	337	693	152	123	910	882
Upstate N.Y.	179	361	15	144	4	6	128	112
N.Y. City	135	536	190	341	85	51	470	489
N.J.	40	146	67	117	35	27	198	208
Pa.	37	104	65	91	28	39	114	73
E.N. CENTRAL	718	1,350	359	463	315	565	469	517
Ohio	256	100	138	77	32	29	79	121
Ind.	108	344	17	45	75	191	32	53
Ill.	151	418	105	2	95	200	249	232
Mich.	129	343	86	311	104	119	79	75
Wis.	74	145	13	28	9	26	30	36
W.N. CENTRAL	568	575	429	519	27	38	171	212
Minn.	217	101	219	170	12	4	94	66
Iowa	97	145	84	131	1	10	9	19
Mo.	118	255	72	171	6	19	43	79
N. Dak.	12	2	1	3	-	-	3	-
S. Dak.	54	2	36	1	-	-	6	9
Nebr.	31	23	-	12	-	2	16	9
Kans.	39	47	17	31	8	3	-	30
S. ATLANTIC	772	866	239	332	830	863	810	1,029
Del.	4	6	4	5	4	4	-	2
Md.	47	37	26	14	101	130	76	98
D.C.	22	11	U	U	19	19	15	2
Va.	57	91	27	103	55	54	93	110
W. Va.	4	3	6	3	-	1	11	15
N.C.	156	51	70	25	207	250	134	136
S.C.	67	47	45	45	109	92	37	30
Ga.	90	106	57	86	109	150	176	232
Fla.	325	514	4	51	226	163	268	404
E.S. CENTRAL	431	352	181	261	237	393	257	371
Ky.	162	82	64	38	18	42	38	41
Tenn.	39	170	28	200	137	246	69	139
Ala.	113	16	78	20	40	47	117	127
Miss.	117	84	11	3	42	58	33	64
W.S. CENTRAL	866	1,307	650	382	279	357	492	832
Ark.	257	79	155	24	19	45	53	78
La.	91	117	81	58	55	82	-	64
Okla.	15	25	2	15	33	62	52	50
Tex.	503	1,086	412	285	172	168	387	640
MOUNTAIN	298	371	188	238	86	90	158	195
Mont.	-	3	-	-	-	-	-	6
Idaho	14	28	-	19	-	-	4	4
Wyo.	-	2	-	2	-	1	1	1
Colo.	62	71	54	30	15	5	48	29
N. Mex.	52	36	29	22	9	8	11	22
Ariz.	127	133	77	81	52	74	57	69
Utah	20	32	20	36	6	-	6	20
Nev.	23	66	8	48	4	2	31	44
PACIFIC	763	1,394	134	1,339	161	172	884	1,195
Wash.	70	297	76	271	23	23	84	99
Oreg.	22	92	40	55	3	6	37	35
Calif.	663	983	-	998	134	142	737	966
Alaska	2	6	1	3	-	-	17	42
Hawaii	6	16	17	12	1	1	9	53
Guam	-	18	U	U	-	2	-	26
P.R.	7	14	U	U	136	79	58	61
V.I.	-	-	U	U	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	4	U	U	U	-	U	17	U

N: Not notifiable. U: Unavailable. -: No reported cases.
*Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending June 2, 2001, and June 3, 2000 (22nd Week)

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2001†	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	598	592	3,856	5,473	2,486	2,834	-	37	-	22	59	33
NEW ENGLAND	24	47	174	131	41	47	-	3	-	1	4	-
Maine	1	1	5	7	5	5	-	-	-	-	-	-
N.H.	-	6	5	11	10	9	-	-	-	-	-	-
Vt.	1	3	5	3	2	4	-	1	-	-	1	-
Mass.	20	27	50	55	3	2	-	2	-	1	3	-
R.I.	2	1	8	6	9	9	-	-	-	-	-	-
Conn.	-	9	101	49	12	18	-	-	-	-	-	-
MID. ATLANTIC	73	98	330	527	351	512	-	2	-	5	7	10
Upstate N.Y.	30	34	103	98	56	54	-	1	-	4	5	-
N.Y. City	23	28	133	211	197	243	-	-	-	-	-	10
N.J.	19	23	70	86	64	86	-	-	-	1	1	-
Pa.	1	13	24	132	34	129	-	1	-	-	1	-
E.N. CENTRAL	77	89	439	719	296	301	-	-	-	10	10	3
Ohio	38	28	106	130	56	48	-	-	-	3	3	2
Ind.	20	10	39	21	13	20	-	-	-	4	4	-
Ill.	10	33	126	306	24	41	-	-	-	3	3	-
Mich.	4	7	148	219	204	177	-	-	-	-	-	1
Wis.	5	11	20	43	-	15	-	-	-	-	-	-
W.N. CENTRAL	24	27	166	402	90	118	-	4	-	-	4	-
Minn.	12	15	12	108	10	15	-	2	-	-	2	-
Iowa	-	-	17	39	9	15	-	-	-	-	-	-
Mo.	10	8	45	182	48	58	-	2	-	-	2	-
N. Dak.	-	1	-	-	-	2	-	-	-	-	-	-
S. Dak.	-	-	1	-	1	-	-	-	-	-	-	-
Nebr.	1	2	21	18	11	19	-	-	-	-	-	-
Kans.	1	1	70	55	11	9	-	-	-	-	-	-
S. ATLANTIC	197	138	779	529	542	469	-	3	-	1	4	-
Del.	-	-	-	9	-	7	-	-	-	-	-	-
Md.	46	34	109	59	62	59	-	2	-	1	3	-
D.C.	-	-	20	7	4	14	-	-	-	-	-	-
Va.	15	28	57	66	59	65	-	-	-	-	-	-
W. Va.	4	4	3	38	14	4	-	-	-	-	-	-
N.C.	23	13	49	85	99	115	-	-	-	-	-	-
S.C.	5	4	23	19	6	3	-	-	-	-	-	-
Ga.	52	38	299	74	141	81	-	1	-	-	1	-
Fla.	52	17	219	172	157	121	-	-	-	-	-	-
E.S. CENTRAL	50	28	138	219	156	198	-	2	-	-	2	-
Ky.	2	11	20	22	17	41	-	2	-	-	2	-
Tenn.	24	11	64	81	62	84	-	-	-	-	-	-
Ala.	23	4	48	26	40	24	-	-	-	-	-	-
Miss.	1	2	6	90	37	49	-	-	-	-	-	-
W.S. CENTRAL	22	33	579	1,001	294	424	-	1	-	-	1	-
Ark.	-	-	29	80	46	46	-	-	-	-	-	-
La.	2	10	43	43	23	69	-	-	-	-	-	-
Okla.	20	21	74	129	46	54	-	-	-	-	-	-
Tex.	-	2	433	749	179	255	-	1	-	-	1	-
MOUNTAIN	91	64	347	377	233	206	-	-	-	1	1	9
Mont.	-	-	5	1	1	3	-	-	-	-	-	-
Idaho	1	2	28	15	6	4	-	-	-	1	1	-
Wyo.	4	1	16	3	16	-	-	-	-	-	-	-
Colo.	21	12	32	79	50	37	-	-	-	-	-	2
N. Mex.	12	14	10	38	63	60	-	-	-	-	-	-
Ariz.	42	29	188	184	69	72	-	-	-	-	-	-
Utah	4	4	30	26	10	12	-	-	-	-	-	3
Nev.	7	2	38	31	18	18	-	-	-	-	-	4
PACIFIC	40	68	904	1,568	483	559	-	22	-	4	26	11
Wash.	1	3	40	134	44	27	-	13	-	2	15	3
Oreg.	12	21	32	106	26	44	-	1	-	-	1	-
Calif.	24	25	820	1,311	410	479	-	7	-	1	8	6
Alaska	2	2	12	6	3	3	-	-	-	-	-	1
Hawaii	1	17	-	11	-	6	-	1	-	1	2	1
Guam	-	-	-	1	-	9	-	-	-	-	-	-
P.R.	-	2	41	151	28	116	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	U	-	U	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	19	U	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
*For imported measles, cases include only those resulting from importation from other countries.
† Of 127 cases among children aged <5 years, serotype was reported for 57, and of those, eight were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending June 2, 2001, and June 3, 2000 (22nd Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	1,155	1,132	-	72	172	38	1,783	2,271	1	8	69
NEW ENGLAND	69	60	-	-	2	1	194	616	-	-	10
Maine	1	5	-	-	-	-	-	12	-	-	-
N.H.	7	4	-	-	-	-	16	59	-	-	1
Vt.	5	2	-	-	-	-	22	121	-	-	-
Mass.	39	37	-	-	-	1	147	394	-	-	8
R.I.	2	3	-	-	1	-	1	7	-	-	-
Conn.	15	9	-	-	1	-	8	23	-	-	1
MID. ATLANTIC	87	113	-	2	11	7	112	205	-	1	5
Upstate N.Y.	36	29	-	1	5	6	95	102	-	1	1
N.Y. City	22	27	-	1	3	-	6	35	-	-	4
N.J.	24	22	-	-	-	-	2	-	-	-	-
Pa.	5	35	-	-	3	1	9	68	-	-	-
E.N. CENTRAL	150	200	-	9	17	8	214	273	-	3	-
Ohio	54	41	-	1	7	8	135	158	-	-	-
Ind.	25	24	-	1	-	-	19	22	-	1	-
Ill.	20	52	-	6	5	-	23	22	-	2	-
Mich.	25	64	-	1	4	-	19	20	-	-	-
Wis.	26	19	-	-	1	-	18	51	-	-	-
W.N. CENTRAL	77	70	-	4	10	-	82	103	1	2	1
Minn.	12	7	-	1	-	-	17	52	-	-	-
Iowa	18	16	-	-	5	-	10	12	-	1	-
Mo.	26	33	-	-	2	-	38	19	-	-	-
N. Dak.	3	2	-	-	-	-	-	1	-	-	-
S. Dak.	4	4	-	-	-	-	3	1	-	-	-
Nebr.	5	4	-	1	1	-	2	3	-	-	1
Kans.	9	4	-	2	2	-	12	15	1	1	-
S. ATLANTIC	213	161	-	17	24	3	94	165	-	1	31
Del.	-	-	-	-	-	-	-	4	-	-	-
Md.	27	16	-	4	5	2	15	43	-	-	-
D.C.	-	-	-	-	-	-	1	-	-	-	-
Va.	22	29	-	2	4	-	10	15	-	-	-
W. Va.	4	7	-	-	-	-	1	-	-	-	-
N.C.	45	27	-	1	3	-	33	44	-	-	23
S.C.	21	13	-	1	7	-	19	16	-	-	6
Ga.	31	27	-	7	2	1	4	20	-	-	-
Fla.	63	42	-	2	3	-	11	23	-	1	2
E.S. CENTRAL	79	80	-	1	4	2	42	45	-	-	4
Ky.	13	15	-	1	-	-	11	25	-	-	1
Tenn.	30	36	-	-	2	-	17	9	-	-	-
Ala.	29	22	-	-	2	2	11	8	-	-	3
Miss.	7	7	-	-	-	-	3	3	-	-	-
W.S. CENTRAL	160	131	-	7	20	1	67	90	-	-	6
Ark.	10	6	-	1	1	1	4	10	-	-	1
La.	52	34	-	2	4	-	2	6	-	-	1
Okla.	18	20	-	-	-	-	1	9	-	-	-
Tex.	80	71	-	4	15	-	60	65	-	-	4
MOUNTAIN	63	54	-	7	13	10	838	343	-	-	1
Mont.	1	1	-	-	1	-	6	7	-	-	-
Idaho	6	6	-	-	-	2	158	41	-	-	-
Wyo.	3	-	-	1	1	-	1	-	-	-	-
Colo.	23	14	-	1	-	4	144	194	-	-	1
N. Mex.	9	6	-	2	1	1	50	56	-	-	-
Ariz.	11	18	-	1	3	1	454	32	-	-	-
Utah	6	6	-	1	4	1	16	9	-	-	-
Nev.	4	3	-	1	3	1	9	4	-	-	-
PACIFIC	257	263	-	25	71	6	140	431	-	1	11
Wash.	38	24	-	-	2	6	46	132	-	-	7
Oreg.	19	30	N	N	N	-	9	42	-	-	-
Calif.	196	198	-	20	59	-	83	231	-	-	4
Alaska	2	3	-	1	4	-	-	6	-	-	-
Hawaii	2	8	-	4	6	-	2	20	-	1	-
Guam	-	-	-	-	6	-	-	2	-	-	1
P.R.	1	6	-	-	-	-	-	1	-	-	-
V.I.	-	-	U	-	-	U	-	-	U	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	U	-	U	U	-	U	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

TABLE IV. Deaths in 122 U.S. cities,* week ending June 2, 2001 (22nd Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	65	45-64	25-44	1-24	<1	
NEW ENGLAND	574	393	116	43	13	9	54
Boston, Mass.	137	83	33	16	3	2	9
Bridgeport, Conn.	30	25	4	1	-	-	2
Cambridge, Mass.	7	6	1	-	-	-	3
Fall River, Mass.	32	25	5	2	-	-	4
Hartford, Conn.	68	42	16	7	2	1	5
Lowell, Mass.	16	15	1	-	-	-	3
Lynn, Mass.	12	10	1	1	-	-	-
New Bedford, Mass.	26	18	5	2	1	-	1
New Haven, Conn.	38	25	7	3	1	2	1
Providence, R.I.	56	41	9	2	1	2	9
Somerville, Mass.	5	3	2	-	-	-	1
Springfield, Mass.	53	35	10	4	3	1	4
Waterbury, Conn.	25	16	8	1	-	-	1
Worcester, Mass.	70	49	14	4	2	1	11
MID. ATLANTIC	1,977	1,418	375	132	34	18	84
Albany, N.Y.	39	29	8	2	-	-	5
Allentown, Pa.	14	12	2	-	-	-	-
Buffalo, N.Y.	80	64	6	8	1	1	13
Camden, N.J.	27	17	7	3	-	-	2
Elizabeth, N.J.	20	11	7	2	-	-	-
Erie, Pa.§	31	22	6	3	-	-	-
Jersey City, N.J.	60	39	14	5	2	-	-
New York City, N.Y.	1,080	765	216	72	20	7	42
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	16	8	5	2	1	-	-
Philadelphia, Pa.	309	214	62	23	6	4	7
Pittsburgh, Pa.§	32	25	2	3	-	2	2
Reading, Pa.	18	15	1	2	-	-	2
Rochester, N.Y.	105	86	14	2	2	2	3
Schenectady, N.Y.	13	11	1	1	-	-	-
Scranton, Pa.§	22	19	2	-	1	-	1
Syracuse, N.Y.	65	49	11	2	1	2	5
Trenton, N.J.	20	13	5	2	-	-	2
Utica, N.Y.	26	20	6	-	-	-	-
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,402	961	283	96	31	31	87
Akron, Ohio	52	38	9	2	1	2	5
Canton, Ohio	26	17	9	-	-	-	3
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	81	52	22	3	2	2	5
Cleveland, Ohio	85	57	19	7	-	2	4
Columbus, Ohio	159	117	28	7	1	6	5
Dayton, Ohio	111	77	25	7	1	1	10
Detroit, Mich.	174	96	49	21	3	5	11
Evansville, Ind.	48	39	6	2	1	-	3
Fort Wayne, Ind.	43	24	13	5	1	-	3
Gary, Ind.	13	7	2	3	1	-	-
Grand Rapids, Mich.	42	29	7	3	1	2	3
Indianapolis, Ind.	197	127	38	18	6	8	9
Lansing, Mich.	23	14	6	2	1	-	5
Milwaukee, Wis.	98	77	16	2	2	1	6
Peoria, Ill.	U	U	U	U	U	U	U
Rockford, Ill.	48	33	11	3	1	-	3
South Bend, Ind.	33	29	1	1	2	-	5
Toledo, Ohio	113	82	15	8	6	2	6
Youngstown, Ohio	56	46	7	2	1	-	1
W.N. CENTRAL	680	486	116	39	22	17	46
Des Moines, Iowa	99	79	14	3	2	1	13
Duluth, Minn.	21	12	5	2	1	1	1
Kansas City, Kans.	31	22	6	2	-	1	3
Kansas City, Mo.	83	54	16	5	4	4	3
Lincoln, Nebr.	43	33	6	2	1	1	1
Minneapolis, Minn.	149	112	21	11	5	-	14
Omaha, Nebr.	58	38	13	3	1	3	5
St. Louis, Mo.	72	43	17	5	4	3	-
St. Paul, Minn.	53	39	8	3	1	2	2
Wichita, Kans.	71	54	10	3	3	1	4

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	65	45-64	25-44	1-24	<1	
S. ATLANTIC	1,226	762	289	101	39	34	82
Atlanta, Ga.	140	83	36	15	6	-	6
Baltimore, Md.	144	80	47	12	2	3	10
Charlotte, N.C.	122	63	34	18	5	2	8
Jacksonville, Fla.	123	78	25	12	5	2	8
Miami, Fla.	127	85	26	10	2	4	15
Norfolk, Va.	45	27	11	-	2	5	2
Richmond, Va.	51	30	13	4	2	2	4
Savannah, Ga.	59	48	8	-	-	3	5
St. Petersburg, Fla.	69	55	6	4	3	1	7
Tampa, Fla.	132	86	27	10	5	4	11
Washington, D.C.	201	116	54	16	7	8	6
Wilmington, Del.	13	11	2	-	-	-	-
E.S. CENTRAL	744	482	155	58	27	22	59
Birmingham, Ala.	130	90	29	6	2	3	13
Chattanooga, Tenn.	U	U	U	U	U	U	U
Knoxville, Tenn.	92	68	16	5	1	2	5
Lexington, Ky.	80	46	21	9	3	1	7
Memphis, Tenn.	161	91	41	16	10	3	9
Mobile, Ala.	106	63	22	9	8	4	7
Montgomery, Ala.	45	33	7	4	1	-	5
Nashville, Tenn.	130	91	19	9	2	9	13
W.S. CENTRAL	1,268	815	267	101	62	23	77
Austin, Tex.	91	56	20	6	5	2	7
Baton Rouge, La.	51	34	10	4	3	-	-
Corpus Christi, Tex.	U	U	U	U	U	U	U
Dallas, Tex.	175	93	46	22	9	5	13
El Paso, Tex.	82	49	23	7	2	1	4
Ft. Worth, Tex.	89	64	18	3	4	-	-
Houston, Tex.	340	204	72	31	25	8	26
Little Rock, Ark.	62	33	18	3	6	2	4
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	216	161	36	15	2	2	9
Shreveport, La.	61	46	9	2	3	1	6
Tulsa, Okla.	101	73	15	8	3	2	8
MOUNTAIN	892	587	187	71	26	20	63
Albuquerque, N.M.	91	64	17	7	3	-	4
Boise, Idaho	U	U	U	U	U	U	U
Colo. Springs, Colo.	62	39	15	5	2	1	2
Denver, Colo.	104	66	22	13	-	2	10
Las Vegas, Nev.	229	158	49	12	6	4	15
Ogden, Utah	22	15	5	2	-	-	2
Phoenix, Ariz.	166	95	40	15	7	9	11
Pueblo, Colo.	23	20	1	2	-	-	3
Salt Lake City, Utah	99	63	20	8	6	2	8
Tucson, Ariz.	96	67	18	7	2	2	8
PACIFIC	1,262	922	224	72	24	18	119
Berkeley, Calif.	11	8	3	-	-	-	-
Fresno, Calif.	68	46	14	7	1	-	5
Glendale, Calif.	27	21	6	-	-	-	1
Honolulu, Hawaii	56	38	15	1	1	1	2
Long Beach, Calif.	57	42	9	3	1	2	6
Los Angeles, Calif.	424	312	71	23	12	6	35
Pasadena, Calif.	31	22	5	2	-	2	2
Portland, Oreg.	U	U	U	U	U	U	U
Sacramento, Calif.	169	124	27	13	3	2	24
San Diego, Calif.	127	86	27	11	1	2	19
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	U	U	U	U	U	U	U
Santa Cruz, Calif.	29	26	3	-	-	-	-
Seattle, Wash.	120	90	21	4	3	2	10
Spokane, Wash.	61	45	12	2	1	1	10
Tacoma, Wash.	82	62	11	6	1	-	5
TOTAL	10,025¶	6,826	2,012	713	278	192	671

U: Unavailable. -:No reported cases.
*Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of >100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.
†Pneumonia and influenza.
§Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.
¶Total includes unknown ages.

Erratum: Vol. 50, No. 20

In the Notice to Readers, "Deferral of Routine Booster Doses of Tetanus and Diphtheria Toxoids for Adolescents and Adults," three errors occurred. The second sentence of the first paragraph should read "Aventis Pasteur (Swiftwater, Pennsylvania) is the only major manufacturer of tetanus and diphtheria toxoids (Td) in the United States." The last sentence of the second paragraph should read "Td use should follow existing recommendations for all other indications, which include 1) persons traveling to a country where the risk for diphtheria is high*; 2) persons requiring tetanus vaccination for prophylaxis in wound management; 3) persons who have received <3 doses of any vaccine containing tetanus and diphtheria toxoids; and 4) pregnant women who have not been vaccinated with Td during the preceding 10 years." The fourth sentence in the fourth paragraph should read "For persons with ≥3 doses of tetanus toxoid-containing vaccine and severe or contaminated wounds, Td should be given only if >5 years have passed since the last dose of tetanus toxoid-containing vaccine."

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